General

Guideline Title

Depression in older adults. In: Evidence-based geriatric nursing protocols for best practice.

Bibliographic Source(s)

Harvath TA, McKenzie G. Depression in older adults. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4th ed. New York (NY): Springer Publishing Company; 2012. p. 135-62.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Kurlowicz L, Harvath TA. Depression. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008 Jan. p. 57-82.

Recommendations

Major Recommendations

Levels of evidence (I–VI) are defined at the end of the "Major Recommendations" field.

Assessment Parameters

- Identify risk factors/high risk groups
  - Current alcohol/substance use disorder (Hasin & Grant, 2002 [Level III])
  - Specific comorbid conditions: dementia, stroke, cancer, arthritis, hip fracture, myocardial infarction, chronic obstructive pulmonary disease, and Parkinson's disease (Alexopoulos, Schulz, & Lebowitz, 2005 [Level IV]; Butters et al., 2003 [Level IV])
  - Functional disability (especially new functional loss) (Cole, 2005 [Level I]; Cole & Dendukuuri, 2003 [Level I])
  - Widows/widowers ("NIH consensus conference," 1992 [Level I])
  - Caregivers (Pinquart & Sorensen, 2004 [Level I])
  - Social isolation/absence of social support (Kraaij, Arensman, & Spinhoven, 2002 [Level I])
  - Diminished perception of light in one's environment (Friberg, Bremer, & Dickensen, 2008 [Level IV])
- Assess all at-risk groups using a standardized depression screening tool and documentation score. The Geriatric Depression Scale-Short Form (GDS-SF) is recommended because it takes approximately 5 minutes to administer, has been validated and extensively used with medically ill older adults, and includes *few* somatic items that may be confounded with physical illness (Pfaff & Almeida, 2005 [Level IV]; Watson & Pignone, 2003 [Level I]).
- Perform a *focused* depression assessment on all at-risk groups and document results. Note the number of symptoms; onset; frequency/patterns; duration (especially 2 weeks); changes from normal mood, behavior, and functioning (American Psychiatric Association

& Task Force on DSM-IV, 2000 [Level VI]).

- Depressive symptoms
- Depressed or irritable mood, frequent crying
- Loss of interest, pleasure (in family, friends, hobbies, sex)
- Weight loss or gain (especially loss)
- Sleep disturbance (especially insomnia)
- Fatigue/loss of energy
- Psychomotor slowing/agitation
- Diminished concentration
- Feelings of worthlessness/guilt
- Suicidal thoughts or attempts; hopelessness
- Psychosis (i.e., delusional/paranoid thoughts, hallucinations)
- History of depression, current substance abuse (especially alcohol), previous coping style
- Recent losses or crises (e.g., death of spouse, friend, pet; retirement; anniversary dates; move to another residence, nursing home); changes in physical health status, relationships, roles

- Obtain/review medical history and physical/neurological examination (Alexopoulos, Katz, & Reynolds, 2001 [Level IV]).
- Assess for depressogenic medications (e.g., steroids, narcotics, sedatives/hypnotics, benzodiazepines, antihypertensives, histamine-2 [H_2] antagonists, beta-blockers, antipsychotics, immunosuppressives, cytotoxic agents).
- Assess for related systematic and metabolic processes (e.g., infection, anemia, hypothyroidism or hyperthyroidism, hyponatremia, hypercalcemia, hypoglycemia, congestive heart failure, and kidney failure).
- Assess for cognitive dysfunction.
- Assess level of functional ability.

Care Parameters

- For severe depression (GDS score 11 or greater, five to nine depressive symptoms [must include depressed mood or loss of pleasure] plus other positive responses on individualized assessment [especially suicidal thoughts or psychosis and comorbid substance abuse]), refer for psychiatric evaluation. Treatment options may include medication or cognitive-behavioral, interpersonal, or brief psychodynamic psychotherapy/counseling (individual, group, family); hospitalization; or electroconvulsive therapy (Areán & Cook, 2002 [Level VI]; Hollon et al., 2005 [Level VI]).
- For less severe depression (GDS score 6 or greater, less than five depressive symptoms plus other positive responses on individualized assessment), refer to mental health services for psychotherapy/counseling (see above types), especially for specific issues identified in individualized assessment and to determine whether medication therapy may be warranted. Consider resources such as psychiatric liaison nurses, geropsychiatric advanced practice nurses, social workers, psychologists, and other community- and institution-specific mental health services. If suicidal thoughts, psychosis, or comorbid substance abuse are present, a referral for a comprehensive psychiatric evaluation should always be made (Areán & Cook, 2002 [Level VI]; Hollon et al., 2005 [Level VI]).
- For all levels of depression, develop an *individualized* plan integrating the following nursing interventions:
  - Institute safety precautions for suicide risk as per institutional policy (in outpatient settings, ensure continuous surveillance of the patient while obtaining an emergency psychiatric evaluation and disposition).
  - Remove or control etiologic agents:
    - Avoid/remove/change depressogenic medications.
    - Correct/treat metabolic/systemic disturbances.
  - Monitor and promote nutrition, elimination, sleep/rest patterns, physical comfort (especially pain control).
  - Enhance physical function (i.e., structure regular exercise/activity; refer to physical, occupational, recreational therapies); develop a daily activity schedule.
  - Enhance social support (i.e., identify/mobilize a support person(s) [e.g., family, confidant, friends, hospital resources, support groups, patient visitors]); ascertain need for spiritual support and contact appropriate clergy.
  - Maximize autonomy/personal control/self-efficacy (e.g., include patient in active participation in making daily schedules, short-term goals).
  - Identify and reinforce strengths and capabilities.
  - Structure and encourage daily participation in relaxation therapies, pleasant activities (conduct a pleasant activity inventory), music therapy.
  - Monitor and document response to medication and other therapies; readminister depression screening tool.
  - Provide practical assistance; assist with problem-solving.
  - Provide emotional support (i.e., empathic, supportive listening; encourage expression of feelings, hope instillation), support adaptive

coping, encourage pleasant reminiscences.

- Provide information about the physical illness and treatment(s) and about depression (i.e., that depression is common, treatable, and not the person's fault).
- Educate about the importance of adherence to a prescribed treatment regimen for depression (especially medication) to prevent recurrence; educate about *specific* antidepressant side effects due to personal inadequacies.
- Ensure mental health community link up; consider psychiatric, nursing home care intervention.

Follow-up to Monitor Condition

- Continue to track prevalence and documentation of depression in at-risk groups.
- Show evidence of transfer of information to postdischarge mental health service delivery system.
- Educate caregivers to continue assessment processes.

Definitions:

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/consensus panels

AGREE Next Steps Consortium (2009). Appraisal of guidelines for research & evaluation II. Retrieved from http://www.agreetrust.org/?o=1397 .

Adapted from: Melnyck, B. M. & Fineout-Overholt, E. (2005). Evidence-based practice in nursing & health care: A guide to best practice. Philadelphia, PA: Lippincott Williams & Wilkins and Stetler, C.B., Morsi, D., Rucki, S., Broughton, S., Corrigan, B., Fitzgerald, J., et al. (1998). Utilization-focused integrative reviews in a nursing service. Applied Nursing Research, 11(4) 195-206.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Depression

Guideline Category

Evaluation

Management

Risk Assessment

Treatment

Clinical Specialty

Family Practice

Geriatrics

Nursing

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Hospitals

Nurses

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Guideline Objective(s)

To provide a standard of practice protocol for assessment and management of depression in older adults

Target Population

Hospitalized older adults

Interventions and Practices Considered

Assessment/Evaluation

1. Identification of high risk groups
2. Use of a standardized assessment tool (e.g., Geriatric Depression Scale-Short Form [GDS-SF])
3. Focused depression assessment
4. Medical history and physical examination
5. Medication history
6. Assessment for contributing systemic and metabolic processes
7. Assessment of cognitive function/dysfunction
8. Assessment of functional status

Management/Treatment

1. Individualized plan of care for all levels of depression
    - Depression management
    - Institution of safety precautions
    - Removal or control of etiologic agents
    - Monitoring nutrition, elimination, rest/sleep
    - Enhancing physical function

- Enhancing social and emotional support
- Maximizing autonomy/personal control/self efficacy
- Identifying strengths and capabilities
- Monitoring of response to medications
- Problem-solving assistance
- Information and education
- Use of community resources

2. Referrals and treatment options for severe and less severe depression

Major Outcomes Considered

- Prevalence of depression among older adults
- Symptoms of depression
- In-hospital suicide attempt rate
- Recognition and referral

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Although the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (described in Chapter 1 of the original guideline document, *Evidence-based geriatric nursing protocols for best practice*, 4th ed.) was created to critically appraise clinical practice guidelines, the process and criteria can also be applied to the development and evaluation of clinical practice protocols. Thus, the AGREE instrument has been expanded (i.e., AGREE II) for that purpose to standardize the creation and revision of the geriatric nursing practice guidelines.

The Search for Evidence Process

Locating the best evidence in the published research is dependent on framing a focused, searchable clinical question. The PICO format—an acronym for population, intervention (or occurrence or risk factor), comparison (or control), and outcome—can frame an effective literature search. The editors enlisted the assistance of the New York University Health Sciences librarian to ensure a standardized and efficient approach to collecting evidence on clinical topics. A literature search was conducted to find the best available evidence for each clinical question addressed. The results were rated for level of evidence and sent to the respective chapter author(s) to provide possible substantiation for the nursing practice protocol being developed.

In addition to rating each literature citation as to its level of evidence, each citation was given a general classification, coded as "Risks," "Assessment," "Prevention," "Management," "Evaluation/Follow-up," or "Comprehensive." The citations were organized in a searchable database for later retrieval and output to chapter authors. All authors had to review the evidence and decide on its quality and relevance for inclusion in their chapter or protocol. They had the option, of course, to reject or not use the evidence provided as a result of the search or to dispute the applied level of evidence.

Developing a Search Strategy

Development of a search strategy to capture best evidence begins with database selection and translation of search terms into the controlled vocabulary of the database, if possible. In descending order of importance, the three major databases for finding the best primary evidence for most clinical nursing questions are the Cochrane Database of Systematic Reviews, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Medline or PubMed. In addition, the PsycINFO database was used to ensure capture of relevant evidence in the psychology and

behavioral sciences literature for many of the topics. Synthesis sources such as UpToDate® and British Medical Journal (BMJ) Clinical Evidence and abstract journals such as Evidence Based Nursing supplemented the initial searches. Searching of other specialty databases may have to be warranted depending on the clinical question.

It bears noting that the database architecture can be exploited to limit the search to articles tagged with the publication type "meta-analysis" in Medline or "systematic review" in CINAHL. Filtering by standard age groups such as "65 and over" is another standard categorical limit for narrowing for relevance. A literature search retrieves the initial citations that begin to provide evidence. Appraisal of the initial literature retrieved may lead the searcher to other cited articles, triggering new ideas for expanding or narrowing the literature search with related descriptors or terms in the article abstract.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

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Adapted from: Melnyck, B. M. & Fineout-Overholt, E. (2005). Evidence-based practice in nursing & health care: A guide to best practice. Philadelphia, PA: Lippincott Williams & Wilkins and Stetler, C.B., Morsi, D., Rucki, S., Broughton, S., Corrigan, B., Fitzgerald, J., et al. (1998). Utilization-focused integrative reviews in a nursing service. Applied Nursing Research, 11(4) 195-206.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Not stated

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Not stated

Evidence Supporting the Recommendations

References Supporting the Recommendations

Alexopoulos GS, Katz IR, Reynolds CF 3rd, Carpenter D, Docherty JP, Expert Consensus Panel for Pharmacotherapy of Depressive Disorders in Older. The expert consensus guideline series. Pharmacotherapy of depressive disorders in older patients. Postgrad Med. 2001 Oct;:1-86. PubMed

Alexopoulos GS, Schultz SK, Lebowitz BD. Late-life depression: a model for medical classification. Biol Psychiatry. 2005 Aug 15;58(4):283-9. [75 references] PubMed

American Psychiatric Association (APA), Task Force on DSM-IV. Diagnostic and statistical manual of mental disorders: DSM-IV-TR. 4th ed. Washington (DC): American Psychiatric Association (APA); 2000. 943 p.

Arean PA, Cook BL. Psychotherapy and combined psychotherapy/pharmacotherapy for late life depression. Biol Psychiatry. 2002 Aug 1;52(3):293-303. PubMed

Butters MA, Sweet RA, Mulsant BH, Ilyas Kamboh M, Pollock BG, Begley AE, Reynolds CF 3rd, DeKosky ST. APOE is associated with age-of-onset, but not cognitive functioning, in late-life depression. Int J Geriatr Psychiatry. 2003 Dec;18(12):1075-81. PubMed

Cole MG, Dendukuri N. Risk factors for depression among elderly community subjects: a systematic review and meta-analysis. Am J Psychiatry. 2003 Jun;160(6):1147-56. [42 references] PubMed

Cole MG. Evidence-based review of risk factors for geriatric depression and brief preventive interventions. Psychiatr Clin North Am. 2005 Dec;28(4):785-803, vii. [64 references] PubMed

Friberg TR, Bremer RW, Dickinsen M. Diminished perception of light as a symptom of depression: further studies. J Affect Disord. 2008

Jun;108(3):235-40. PubMed

Hasin DS, Grant BF. Major depression in 6050 former drinkers: association with past alcohol dependence. Arch Gen Psychiatry. 2002 Sep;59(9):794-800. PubMed

Hollon SD, Jarrett RB, Nierenberg AA, Thase ME, Trivedi M, Rush AJ. Psychotherapy and medication in the treatment of adult and geriatric depression: which monotherapy or combined treatment. J Clin Psychiatry. 2005 Apr;66(4):455-68. [110 references] PubMed

Kraaij V, Arensman E, Spinhoven P. Negative life events and depression in elderly persons: a meta-analysis. J Gerontol B Psychol Sci Soc Sci. 2002 Jan;57(1):P87-94. PubMed

NIH consensus conference. Diagnosis and treatment of depression in late life. JAMA. 1992 Aug 26;268(8):1018-24. PubMed

Pfaff JJ, Almeida OP. Detecting suicidal ideation in older patients: identifying risk factors within the general practice setting. Br J Gen Pract. 2005 Apr;55(513):269-73. PubMed

Pinquart M, Sorensen S. Associations of caregiver stressors and uplifts with subjective well-being and depressive mood: a meta-analytic comparison. Aging Ment Health. 2004 Sep;8(5):438-49. PubMed

Watson LC, Pignone MP. Screening accuracy for late-life depression in primary care: a systematic review. J Fam Pract. 2003 Dec;52(12):956-64. [40 references] PubMed

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for selected recommendations (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Patient

- Maintenance of patient safety
- Appropriate evaluation by psychiatric services for severe depression
- Reduction of symptoms indicative of depression (e.g., reduction in the Geriatric Depression Scale [GDS] score and resolution of suicidal thoughts or psychosis)
- Improved daily functioning

Health Care Provider

- Early recognition of patient at risk, referral, and interventions for depression
- Improved documentation of outcomes

Institution

- Increased identification of patients with depression
- No increase in the number of in-hospital suicide attempts
- Increased referrals to mental health services
- Increased referrals to psychiatric nursing home care services
- Improved staff education on depression recognition, assessment, and interventions

Potential Harms

Not stated

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Chart Documentation/Checklists/Forms

Foreign Language Translations

Mobile Device Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2003 (revised 2012)

Guideline Developer(s)

Hartford Institute for Geriatric Nursing - Academic Institution

Guideline Developer Comment

The guidelines were developed by a group of nursing experts from across the country as part of the Nurses Improving Care for Health System Elders (NICHE) project, under sponsorship of the Hartford Institute for Geriatric Nursing, New York University College of Nursing.

Source(s) of Funding

Hartford Institute for Geriatric Nursing

Guideline Committee

Not stated

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Kurlowicz L, Harvath TA. Depression. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008 Jan. p. 57-82.

Guideline Availability

Electronic copies: Available from the Hartford Institute for Geriatric Nursing Web site _____.

Copies of the book *Evidence-Based Geriatric Nursing Protocols for Best Practice*, 4th edition: Available from Springer Publishing Company, 536 Broadway, New York, NY 10012; Phone: (212) 431-4370; Fax: (212) 941-7842; Web: www.springerpub.com _____.

Availability of Companion Documents

The following are available:

- *Try This®* - issue 4: The Geriatric Depression Scale (GDS). New York (NY): Hartford Institute for Geriatric Nursing; 2 p. 2012. Electronic copies: Available in PDF in English [   ] and Spanish [   ] from the Hartford Institute for Geriatric Nursing Web site.
- The Geriatric Depression Scale (GDS) Short Form Assessment. How to Try This video. Available from the Hartford Institute for Geriatric Nursing Web site [   ].

The ConsultGeriRN app for mobile devices is available from the Hartford Institute for Geriatric Nursing Web site [   ].

Patient Resources

None available

NGC Status

This summary was completed by ECRI on February 2, 2004. The information was verified by the guideline developer on February 26, 2004. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI Institute on November 2, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs. This summary was updated by ECRI Institute on June 18, 2008. The updated information was verified by the guideline developer on August 4, 2008. This NGC summary was updated by ECRI on June 24, 2013. The updated information was verified by the guideline developer on August 6, 2013.

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